	RS FOR MEDICARE	& MEDICAID		Poaccopular in .	FORM AP	PROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION WILL	(X3) DATE SURV COMPLETE	/EY
		295079	B. WING_		C	
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	05/18/2	:007
EVERGE	REEN MOUNTAINVIEW	/ HEALTH	;	201 KOONTZ LANE CARSON CITY, NV 89701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE C	(X5) OMPLETION DATE
F 000	INITIAL COMMENT	s	F 000			
	the result of three o	Deficiencies was generated as complaint investigations lity on 5/15/07 and finalized on	¢.	DISCLAIMER CLAUSI		
	of the Health Division prohibiting any crime actions or other clai	nclusions of any investigation on shall not be construed as inal or civil investigations, ms for relief that may be by under applicable federal,	<b>%</b> ()	PREPARATION AND DE EXECUTION OF OF CORRECTION DOES NOT CONST PROVIDER'S ADMISSION OF OR AGREE THE FACTS ALLEGED OR CONCLUSIONS IN THE STATEMENT OF DEFICIENCIES. T CORRECTION IS PREPARED AND/OR SOLELY BECAUSE IT IS REQUIRED BY SIONS OF FEDERAL AND STATE LAW	ITUTE THE MENT WITH SET FORTH EXECUTED THE PROVE	
	Complaint #NV00014983 was a facility reported injury of unknown origin. The injury was substantiated. No deficiency was cited based on the facility's actions.  Complaint #NV00014957 alleged the facility failed to provide the necessary care. The complaint was unsubstantiated.			RECE	VED	
				JUN 19	2007	
	event of inadequate substantiated. See	1		AND CERTIFIC CARSON CITY, I	ATION NEVADA	
F 353   SS=D	The facility must have provide nursing and maintain the highest and psychosocial we determined by reside	e sufficient nursing staff to related services to attain or practicable physical, mental, ell-being of each resident, as ent assessments and	F 353	Residents 6, 7 have stabilized blosugars with no further effects frincident. Resident 8 has ongoing activity, but no apparent adversion this incident. Resident 9's has healed completely with no complications.	om this g seizure se effects	
	numbers of each of personnel on a 24-h care to all residents	vide services by sufficient the following types of our basis to provide nursing in accordagge with resident		All residents on Station 3 were effor negative outcomes from this No negative outcomes were iden	incident.	5-1-07
CORRIORY	A A A	ER/SUPPLIED DEPRESENTATIVE'S SIGN	ATURE	RON PETERSEN ADMINISTRATOR	• •	DATE
v deficienc				No.	6-1	9-07

Any deficiency statement enting with an astorist () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES					APPROVED
		& MEDICAID ( VICES	<del></del> -			OMB NO.	0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULTI IILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 05/18/2007	
_	<del>-</del>	295079	B. WI	NG_			
	ROVIDER OR SUPPLIER	VHEALTH		2	REET ADDRESS, CITY, STATE, ZIP CODE 01 KOONTZ LANE CARSON CITY, NV 89701	, 00710	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	care plans:  Except when waive section, licensed nupersonnel.  Except when waive section, the facility in urse to serve as a duty.  This REQUIREMENT by: Based on medical in procedure review, a determined that the adequate staff to prof 9 residents. (Restricted with the stated that on 4/28/6 (LPN) who was sche that on 4/28/6 (LPN) who was sche the resident care manurse on call for 4/2 the nurse on call for	d under paragraph (c) of this irses and other nursing d under paragraph (c) of this must designate a licensed charge nurse on each tour of the irse irse irse irse irse irse irse irs	F	353	A job description will be writter "On Call Nurse" which clearly oresponsibility to ensure that all in the facility receive adequate of that the facility is adequately stated job description for the Resident Managers will be annotated to define their responsibilities with staffing also. Resident Care Mawill all sign their amended job description  All nurses who accept the "On Onurse" assignment will sign the description and receive education concerning the Staffing and concerning to a descriptions and monitoring to a dequate staffing in the facility.	defines the residents care and affed. The Care clearly cregard to magers  Call job on cerage	6-30-07

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some time during the shift on 4/28/07, LPN #2 left

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## DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED	: 06/05/2007
FORM	APPROVED
OMB NO	. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		295079	B. WING			C 05/18/2007	
	NAME OF PROVIDER OR SUPPLIER  EVERGREEN MOUNTAINVIEW HEALTH			2	REET ADDRESS, CITY, STATE, ZIP CODE 101 KOONTZ LANE CARSON CITY, NV 89701		0/2001
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	a note in the director stating that she work Station Three. LPN Three. The administ the DON were hom have been called rewhen asked how lot the nurse on call poused it for several yhad been any previous call, he stated tho other problems. Wo covering a nurse cathat there was not at the DON. The she tried to call Statist three times. She stone and left a mess Station One to give she (LPN #2) would and Station Three the who called in sick. If an LPN and an age One. Station Two would cover both Station Three that the DON stated that from 5:00 AM to 5:00 worked from 5:00 P that on 4/28/07, the Three stayed until 7 blood sugar checks medications. She s report to LPN #2 an were two blood sugar noon. Review of	ge 2 or of nursing's (DON) mailbox ald not be responsible for all #2 did not cover Station strator stated that both he and e all day on 4/28/07 and could regarding the staffing concerns. On had the facility been using resition, he stated that they had rears. When asked if there ous problems with the nurse at there had not been any hen asked for the policy on alling off for a shift, he stated a policy for covering call offs.  OAM, an interview was done DON stated that on 4/28/07 attended to speak with LPN #2 attended she then called Station sage with the charge nurse on the message to LPN #2 that all be covering both Station Two hat day to cover for the nurse on the DON stated that there was not LPN scheduled for Station was typically very light for atments, and that LPN #2 attended to Station Two and Station Three. The day shift LPNs worked to PM and the night LPNs M until 5:00 AM. She stated night LPN #3 from Station :30 AM to do the morning and to pass the early morning tated that LPN #3 had given d reminded her that there are that needed to be checked the report sheet for 4/28/07 were two residents on Station	F	353			

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	TMENT OF HEALTH	HAND HUMAN RVICES			FORM	): 06/05/2007 I APPROVED ): 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		295079	B. WING	3		C 1 <b>8/2007</b>
NAME OF F	ROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CO		
EVERGR	EEN MOUNTAINVIEV	V HEALTH		201 KOONTZ LANE CARSON CITY, NV 89701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Three that had elevinote that a blood so The DON stated the and would have been had known there we arrangements. She that LPN #2 had no she came into the full 4/29/07 and found a #2 had written and On 5/15/07 at 10:40 with the administrate 4/28/07. The administrated that she was 7:00 AM until 2:00 made initial rounds Station One that the Three. She stated she could find no or that she would go b Station Three.  On 5/17/07 at 1:45 with LPN #1, the restation Three. She LPN #1 stated that been willing to come	rated AM blood sugars with a ugar check was due at noon. at she was home on 4/28/07 en available to come in if she as a problem with the staffing e stated that she did not know at covered Station Three until facility on the evening of a note dated 4/28/07 that LPN	F 35	53		

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Review of the facility census for 4/28/07 revealed that the total census was 128. Station One had 49 residents, Station Two had 38 residents, and

Resident #6: On 5/17/07 the medical record of

Station Three had 41 residents.

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED: 06/05/2007 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		COMPLETED

		IDENTIFICATION NUMBER		ILDING	<u> </u>	COMPLETED	
		295079	295079 B. WING			1	C <b>/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  EVERGREEN MOUNTAINVIEW HEALTH				20	EET ADDRESS, CITY, STATE, ZIP CODE 11 KOONTZ LANE ARSON CITY, NV 89701		
(X4) ID PREFIX TAG			ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 353	Resident #6 was re admitted to the facil re-admission date of diagnoses: chronic dysphagia, diabetes hypercholesterolem hypertension, vascuureteral disorders. medical record revedocumentation that at 11:00 AM and that was 438 (elevated), sugars for the mont revealed a range of next highest blood sphysician orders for there was insulin co	viewed. Resident #6 was lity on 8/29/05 with a of 6/19/06 with the following blood loss anemia, a mellitus, and renal and Review of Resident #6's ealed for 4/28/07, no the blood sugar was checked at his blood sugar at 5:30 PM. Review of the 5:30 PM blood the of April for Resident #6's sugar. Review of the sugar. Review of the Resident #6 revealed that overage to be given for a blood Resident #6's 8:00 PM blood	F	353			
	Resident #7 was readmitted to the facil re-admission date of diagnoses: cellulitis diabetes mellitus, dineuropathy, malaise gastroparesis, esophypertrophy, and hy Resident #7's medic documentation that of Lantus insulin 10 sugar was not document and the blood sugar (elevated). Review sugars for the montirevealed a range of physician orders for	17/07 the medical record of viewed. Resident #7 was ity on 12/19/06 with a of 2/16/07 with the following of the leg, depression, labetic retinopathy, diabetic e and fatigue, senile dementia, hageal reflux, benign prostate poglycemia. Review of cal record revealed no on 4/28/07 the 7:00 AM dose units was given, the blood mented as done at 11:00 AM, for 5:30 PM was 400 of the the 5:30 PM blood h of April for Resident #7 111 to 401. Review of the Resident #7 revealed that verage for a blood sugar of					

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## DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/05/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295079		1 '	IULTIP ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		295079	B. WI	1G		C 05/18/2007	
NAME OF PROVIDER OR SUPPLIER  EVERGREEN MOUNTAINVIEW HEALTH				20	EET ADDRESS, CITY, STATE, ZIP CODE 1 KOONTZ LANE ARSON CITY, NV 89701		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORPREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
F 353	351-400. Resident 199 (elevated).  Resident #8: On 5/Resident #8 was readmitted to the faci re-admission date of diagnoses: convuls mental disorder, se history of alcoholism pancreatic disease medical record reversal record reco	#7's 8:00 PM blood sugar was  /17/07 the medical record of eviewed. Resident #8 was lity on 5/10/07 with a of 1/4/07 with the following sions, aphasia, transient enile delusion, atrial fibrillation, m, hypertension, and Review of Resident #8's ealed that on 4/28/07 there tion that he received Depakote resizures and scheduled to be and 2:00 PM. There was no received Dilantin 300 mg sions and scheduled to be Review of the interdisciplinary 4/28/07 at 5:15 PM patient lying next to bed having sech very garbled, was given and Ativan as ordered. 20 minutes." The following 8:00 PM documented, "patient ctivity. Was given MSO4 and fect. Episode lasting 15  view was done with the DON #8's seizure activity. She of unusual for Resident #8 to see the stated that he did not and was talking during the	F	353			
	When asked if she	CNA) #3 was interviewed. worked on Station Three on that she came in at 2:00 PM					

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## DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 06/05/2007 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		IPLE CONSTRUCTION IG	COMPLETED	
		295079	B. WING		·	ł .	C <b>B/2007</b>
NAME OF PROVIDER OR SUPPLIER  EVERGREEN MOUNTAINVIEW HEALTH			<u> </u>	2	REET ADDRESS, CITY, STATE, ZIP CODE 101 KOONTZ LANE CARSON CITY, NV 89701	1 05/10	5/200 <i>7</i>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	on 4/28/07. She saduring CNA report surprised that Resistated that after roufirst. She stated that on her leg and clott leg. CNA#3 stated LPN #2 for some of stated that LPN #2 dressings, but that Resident #9's leg.  On 5/17/07 at 2:25 When asked what \$4/28/07, she stated shift, from 6 AM un CNA #4 stated that were working the flousy doing their wo LPN #2 come to St CNA #4 stated the the floor personally #2 came to the flooseizure activity. Re record interdisciplin reveal any entry by asked if she was averally had their blood sugmedications, she st of that, but that she acting like they did stated that after wo	aid it was reported to her that she should not be dent #9 had a skin tear. She are Resident #9 had dried blood hing from a skin tear on her she went to Station 2 to ask intment for Resident #9. She handed her the ointment and she did not come to evaluate PM CNA #4 was interviewed. Shift she had worked on that she had worked the day til 2 PM on Station Three. The usual amount of CNAs for on 4/28/07 and they were rk. When asked did she see ation Three during her shift, she did not see her come to but that she heard that LPN red to check on Resident #8 for view of Resident #8's medical ary progress notes failed to LPN #2 for 4/28/07. When ware that the residents had not ars checked or received their ated that she was not aware could tell the residents were not get their medications. She rking with the residents every of tell the difference in their	F	353			

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